Operational Assessment of Three Ministry of Health Provincial Hospitals in Kenya

July 1999

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OPERATIONAL ASSESSMENT

OF THREE

MOH PROVINCIAL HOSPITALS

PURPOSE:

To undertake an operational assessment of three (3) Provincial Hospitals to identify the organization's performance, its strengths and weaknesses, the feasibility for achieving a new level of institutional autonomy and sustainability, and if the hospital could potentially benefit from AFS technical assistance. The assigned provincial hospitals were Nyanza, Nyeri, and Rift Valley.

PROCESS:

The AFS Project Team performed a *rapid* focused collection and analysis of operational data, individual and small group interviews, and on-site observations.

METHODOLOGY:

I. Facility Identification, Profile and Scope of Services

II. Senior Management Interviews

III. Middle Management/Department Head Interviews and Department Tour

IV. Ward Rounds – Patient Care Environment

V. Exit Conference – Summary of Preliminary Findings and Management Feefback for Clarification or Additional Supportive Information

VI. Assessment Findings and Conclusions

VII. Recommendations for Improvement

RECOMMENDATIONS:

Recommendations are made to improve organizational performance and quality of services, control costs, increase revenues and cash collection, and improve patient and staff satisfaction.

MSH envisages that it will only be able to provide focused technical assistance to two of the three hospitals assessed within the time frame of the present contract with USAID, which until a contract modification is effected is September 30, 2000. As a result, MSH recommends that it rapidly enter into a *memoranda of understanding* and then develop detailed activity plans with Nyanza and Rift Valley Provincial General Hospitals. Thereafter technical assistance may be delivered by MSH to these hospitals. It should be noted that this selection is based upon the objective scoring criteria presented on page 24 of this report, which identifies those hospitals where practical improvements to hospital management in line with the contract objectives are considered most likely to be attained in the available time frame.

NYANZA PROVINCIAL GENERAL HOSPITAL – KISUMU

MAY 24-25, 1999

I. HOSPITAL PROFILE:

NYANZA PROVINCIAL GENERAL HOSPITAL Key Statistics	
Catchment Area Population	Unknown
Total No. Beds	354
Total No. of Staff	554
Doctors/Consultants	18
Medical Officers	5
Clinical Officers	16
Nurses	313
Other / Admin. / Subordinate	202
Expenditure – Cost Sharing – 1998	32,292,599
Expenditure - Recurrent	14,453,116
Drugs & Supplies (%) -C. Sharing – 1998	29%
Drugs & Supplies (%) –Recurrent	4%
Recurrent AIEs -1998/99	16,749,300
Income – Cost Sharing –1998	14,192,102
NHIF Income	5,044,400
NHIF Outstanding Claims	7,826,955
Cash Collection Points	2
Total Admissions – 1998	11,269
ALOS	10
Occupancy %	81%
Total Outpatient Visits – 1998	148,385
Total Surgical Operations – 1998	850
Total OB Deliveries – 1998	3,980
Daily Inpatient Charge (General ward)	100
Satellite Units	Amenity Annex

NYANZA PROVINCIAL GENERAL HOSPITAL

KISUMU

OPERATIONAL ASSESSMENT ACTIVITY SCHEDULE

DATE/TIME	DEPARTMENT	INDIVIDUAL	PURPOSE
May 24, 9am	Executive Mgt.	Dr. Odondi, Med. Supt., and Exec. Management Team- Dr. Oduor, Mr. Ochieng, Mrs. Siaya, Ms. Auma, and Mr Motonu	Organogram, scope of services, bed complement, and review agenda
11am	Personnel	Mr. Juma, Pers. Officer	Staffing complement, shortages/overages, problems
11:30am	Accounting	Mr. Mutonu	Financial- budget, revenue/expense
11:30am	Purchasing/stores	Mr. Madoya	Procedures- purchasing, stores and distribution
12 noon	Med. Staff leaders	Drs. Odondi, Oduor	Bylaws, Manpower concerns, barriers to quality
2pm	Pharmacy	Mr. Rae	Functions, Concerns
2:30pm	Laboratory	Mr. Omondi	Needs, Concerns
3pm	Med. Records	Mr. Owiti	Needs, Concerns
May 25, 9am	Nursing Admin	Mrs. Siaya, Mrs. Kotonya, Mrs. Omollo	Orgamogram, barriers to quality care, CE, wards tour
12:30	Radiology,	Mr. Ndiege	Needs, Concerns
2pm	Exit Conference	Dr. Odondi, Exec.Mgmt. Team	Presentation of findings, recommendations

II. ORGANIZATIONAL ISSUES:

GENERAL OBSERVATIONS-

- Staff friendly and informed
- Senior management team actively involved, informed, credible
- Overall external environment appears good and services accessible

FINDINGS-

1. Operating organization (organogram) is functional, supported by staff, appropriately designed for timely decision-making and communication
2. No institutional strategic plan
3. Hospital Board, newly reappointed, needs clarification of its authority and responsibilities, and those of management
4. There is a need to strengthen the management skills at all levels
5. The medical consultant staff in general represents the hospital leadership, but does not appear to participate in management meetings
6. Victoria Amenity Hospital (PGH Annex 3.5km off campus) 16 beds, low utilization, needs maintenance. Mainly because of distance and poor telephone service, the staff feels the PGH does not adequately support
7. Medical records department is handicapped by lack of space. The department will soon be relocated to OPD and the concern resolved
8. The government's cumbersome and tedious procedures for obtaining necessary supplies and pharmaceuticals cause unnecessary delays in procurement and adversely impact the hospital's ability to meet patients needs
9. Medical supplies and drugs provided by MSCU "kits" are not cost effective because the number and items do not correspond with hospital needs
10. There is a professional library

RECOMMENDATIONS-

1. Senior management in collaboration with the Board should develop a strategic plan for the next 1 to 3 years
2. Board members would benefit from a training workshop for new board members, to clarify their roles and responsibilities, and those of management. Technical support is required.
3. Replace current method of purchasing / stores / distribution with a *system of supplies management.* A system that establishes a clear flow of process activities to control costs of procurement and inventory beginning with user requests and ending with timely distribution of requested items to user departments. This system will also help to improve availability of supplies to user departments. Technical support is required.
4. A *management development program* to encompass management theory, leadership and team building, communication skills, planning and goal setting, and financial skills and budgeting should be planned. *Customer care training* for all staff is also suggested. Technical support is required.

5. Daily vehicle courier service between the PGH and the Victoria Annex would greatly improve both services to patients and staff (patient/patient specimen referrals for diagnostic/treatment services not available at the Annex). This would have a positive impact on improving staff morale and productivity, and patient satisfaction.
6. There is an economic need for the Annex to increase patient admissions to be more economically viable. However, prior to promoting the services to the "paying" public and private clinics, the facility needs to improve the overall appearance and availability of supplies and services in order to attract new patients and retain present clients
7. Organize a multidisciplinary *Space Committee* to review utilization of existing space for appropriateness
8. Include members of the consultant medical staff in management meetings particularly for their input into planning and problem solving related to patient care.

II. PATIENT CARE ISSUES:

FINDINGS-

1. Some of the wards are frequently overcrowded which increases the risk of hospital-acquired infections and patient/family dissatisfaction with services/care
2. Some of the wards have relatively low average occupancy, especially the amenity wards and the eye ward
3. The staff, in general, complain about the lack of supplies and basic patient care equipment
4. There is some interest to establish home care for HIV/AIDS patients.
5. Hospice services are available
6. Consultants needed to improve medical care: Orthopedist, Cardiologist, Nephrologist

RECOMMENDATIONS-

1. Utilization of the wards needs to be studied. Some consolidation of beds/wards may be possible and will help to offset overcrowding, lower the risk of infections, and overwork of nursing staff. The aforementioned space committee may be useful.
2. A pilot demonstration should be implemented to improve distribution of supplies to user departments, especially patient wards. It is suggested to utilize stores clerks. Using nurses as delivery staff contributes to the perceived shortage of nursing staff, removes the nurse from the patient care environment and negatively impacts the nurse's job satisfaction and productivity.
3. The concept of maintaining "ward stock" should be evaluated in terms of improving inventory control and reducing the opportunities for hoarding and pilferage. The desired outcome could conceivably help to reduce frequent supply shortages and lower costs. A special task force committee is suggested to study the required stock items based on levels of patient care and design a new system of "ward stock".
4. Organize a multidisciplinary *Personnel Committee* to review staffing levels, based on need, by department, to achieve a more equitable distribution of appropriate staff. There is a general perception that some departments are overstaffed based on service volume.
5. Organize a committee of nurses, clinical officers, medical officers, and consultants to develop: 1) *admission criteria; 2) clinical treatment protocols; 3) utilization review plan*- to review extended inpatient stays, and appropriate utilization of hospital resources. These activities are designed to control unnecessary admissions and extended stays to eliminate overcrowding, control/reduce operating costs, and improve quality of patient care. Technical support would be beneficial.

III. FINANCE AND ACCOUNTING ISSUES:

FINDINGS-

1. A Financial Management Information System (FMIS) is not in place. The management does not receive accurate and timely information to support planning and timely decision-making. Patient activity and financial data are not integrated. The cash accounting system is in place. All accounting is done manually.
2. An accounts assistant who is on secondment from the District Treasury heads the accounts department. He has CPA I, Section I qualification. All other accounting department staff are not trained accountants but mainly bookkeeping clerks with basic secondary education. None are computer literate.
3. Revenue and Expenditure budgets are not prepared. Monies are expended based on the amount of money collected.
4. Costing of hospital services exercise has not begun despite two members of staff being trained in April this year on how to carry out the exercise.
5. There are two cash collection points- one is NHIF located near the amenity ward, which is at the furthest end of the hospital proper and serves inpatients in the all nine (9) wards. The other is located at the administration block and serves the outpatients. Limiting of cash points to only two was done for control purposes.
6. The involvement of the District Treasury in the approval of payment vouchers leads to unnecessary delays in procurement of goods and services. Where emergencies have occurred in the past, this delay has resulted in an inevitable spending of FIF funds at source (before banking).
7. There is no formal analysis of volume of services rendered and revenue earned from those services. This means that the hospital does not estimate the expected collections based on workload statistics.
8. The hospital management does not remit 25% of collections to DMOH for PHC activities as per the FIF policy guidelines. The hospital management intends to use the 25% of FIF to resume mobile clinics, which stopped due to lack of transport. The management stopped remitting the funds because they were not convinced that the DMOH was using the 25% FIF funds on PHC activities.
9. The hospital has introduced ward clerks whose roles are to identify NHIF patients and to maintain inpatient billing records. They also act as gatekeepers to prevent inpatients from absconding.
10. The hospital's total revenue position is not known because not all income due to the hospital is captured.

RECOMMENDATIONS-

1. Design and implement a Financial Management Information System (FMIS). Critical to effective management performance is the need for accurate and timely information. The FMIS should be modular, so it can be phased in, and will integrate patient activity and financial data. This will require some technical support.
2. With the MoH moving towards decentralization of public hospitals, qualified accounting staff to manage the hospital finances will be a necessity. Since it is not possible to attract qualified accountants in public hospitals, the hospital management should consider investing in the training of selected existing clerks in accounting and basic computer applications.
3. The hospital management should involve all departments/units in preparation of annual revenue and expenditure budgets. The department heads should be made responsible for their departmental budgets. The budgets should be reviewed on a quarterly basis by comparing the actual collections and expenditures against what was budgeted. Variances should be explained.
4. Understanding how much it costs to provide health services is critical to managers in planning (adding or discontinuing services), and fee setting. The hospital should therefore start the costing exercise by collecting costs and workload data for the current financial year.
5. Whereas cash control measures are encouraged at all levels, the hospital should consider the distances that patients have to walk to pay for services and also, how long they have to wait in the queues before paying. An additional cash point at OPD to serve the outpatient clinics is encouraged, as the patient volume at OPD is quite high
6. The NHIF office (cash point) should be moved to a more central location for security reasons and also for better access for paying inpatients. If strict cash control systems were in place, in the interest of patient access, the two existing points could easily be expanded to four to better serve the patients.
7. The accounting functions for the FIF funds should be done at the hospital since the District Treasury has accountants already working at the hospital. This will minimize the frustrations of the hospital staff and also expedite approval of valid expenditure. All accounting books and records should be maintained by hospital.
8. Departments should be encouraged to estimate the expected revenue based on services provided. This should then be compared with the reported revenue. Any variances should be explained. This check will ensure that cashiers/ revenue clerks do not tamper with receipts.
9. All services provided to the patients should be billed and recorded whether the patient is paying or not. This will allow the management to know the total revenue potential and how much revenue is lost through waivers, exemptions, absconders and other bad debts.
10. It is recommended that the remittance of 25% of FIF monies to DMOH for PHC activities be done as per FIF policy guidelines. Issues of accountability of those funds by the DMOH should be raised with the relevant authorities.
11. The deployment of clerks to each ward for inpatient billing should be assessed to determine their contribution in increasing revenues and supporting nursing care by assisting with non nursing duties. A cost benefit analysis should be done to establish cost effectiveness.

V. HOSPITAL MANAGEMENT FEEDBACK:

At the conclusion of the assessment survey, a summation conference was held with senior hospital management to present the preliminary findings and conclusions. This was the same group of individuals present at the opening meeting with the medical superintendent. This summation conference is also an opportunity for senior management feedback, to provide additional supportive information and ask questions for clarification.

Additional Feedback:

- Need management training- supervisory skills, communication, budgeting
- Need customer care training for staff
- Shortage of supplies and basic patient care equipment for diagnosis and treatment
- Newly designated eye ward is planned to open late 1999
- The MOH personnel disciplinary procedures are not effective- have a negative impact on improving staff discipline and productivity

NYERI PROVINCIAL GENERAL HOSPITAL – NYERI

JUNE 3-4, 1999

I. HOSPITAL PROFILE:

NYERI PROVINCIAL GENERAL HOSPITAL **Key Statistics**	
Catchment Area Population	
Bed Size	400
Total No. of Staff	633
Doctors/Consultants	13
Medical Officers	10
Clinical Officers	27
Nurses	328
Clinical staff	27
Other / Admin. / Subordinate	247
Expenditure – Cost Sharing – 1998	11,730,986
Expenditure - Recurrent	10,502,727
Drugs & Supplies (%) -C. Sharing – 1998	
Drugs & Supplies (%) –Recurrent	
Recurrent AIEs –1998/99	10,564,960
Income – Cost Sharing –1998	14,213,759
NHIF Income	1,894,000
NHIF Outstanding Claims	1,181,000
Cash Collection Points	3
Total Admissions – 1998	12,455
ALOS	
Occupancy %	82%
Total Outpatient Visits – 1998	14,400
Total Surgical Operations – 1998	
Total OB Deliveries – 1998	5,911
Daily Inpatient Charge (General ward)	100
Satellite Units	

NYERI PROVINCIAL GENERAL HOSPITAL

NYERI

OPERATIONAL ASSESSMENT ACTIVITY SCHEDULE

DATE/TIME	DEPARTMENT	INDIVIDUAL	PURPOSE
June 3, 9am	Executive Mgt.	Dr. Githiru, Med. Supt., and Exec. Management Team- Dr Thuo, Mr. Ragwa, Mrs. Waithaka	Organogram, scope of services, bed complement, and review agenda
11am	Personnel	Mr. Kimani, Pers. Officer	Staffing complement, shortages/overages, problems
11:30am	Accounting	Mr. Mwangi	Financial- budget, revenue/expense
11:30 am	Purchasing/stores	Mr. Gitobu	Procedures- purchasing, stores and distribution
12 noon	Med. Staff leaders	Drs. Githiru, Thuo, Mburu	Bylaws, Manpower concerns, barriers to quality
2pm	Pharmacy	Ms. Mucheru	Functions, Concerns
2:30pm	Laboratory	Mr. Maina	Needs, Concerns
3pm	Med. Records	Mr.Karoki	Needs, Concerns
June 4, 9am	Nursing Admin	Ms., Njugu	Organogram, barriers to quality care, CE, wards tour
12:30	Radiology,	Mr. Kamenya	Needs, Concerns
2pm	Exit Conference	Dr. Githiru, Mgmt. Staff	Presentation of findings, recommendations

II. ORGANIZATIONAL ISSUES:

GENERAL OBSERVATIONS-

- Numerous separate facilities / structures dispersed over 27 acres with a perimeter fence that needs significant repairs to be effective. There is no security staff to provide a safe and secure environment for patients, staff, visitors, and protect hospital assets. (physiotherapy was recently broken into).
- Without exception all of the buildings are severely deteriorated which contributes to a poor environment of patient care and poor staff morale and job satisfaction.
- Hospital provides a broad scope of patient services much the same as other PGHs
- plus a functioning youth health clinic (1998).
- The hospital staff are friendly and professional. Their positive attitude is commendable given the difficult working environment and the lack of supplies and basic patient care equipment. This positivism can only be the result of a supportive and participatory senior management team.

FINDINGS-

1. Department heads are responsible for developing departmental budgets, but there is no corresponding expenditure plan.
2. Hospital board needs clarification of their roles/responsibilities, and those of management. Some technical support is required.
3. The operating organization (organogram) is appropriately structured.
4. There is no computerization. All information is collected and reported manually.
5. Perhaps of the most significant operational problems at the time is the water supply. It is both non-dependable and of poor quality (hardness). The source is a borehole. Staff are seen carrying water from the source to the patient wards.
6. There is no standby power due to a lack of maintenance.
7. From a macro viewpoint, staffing levels appear excessive in some services and lean in others, especially nursing. A combination of things may cause a perceived shortage of nursing staff: 1) an average bed occupancy of greater than 80% will stress all resources; 2) performing non nursing duties, i.e., leaving the ward to fetch water and patient drugs and supplies.
8. Drugs and supplies are mainly provided by the MSCU. Storage and accountability for these items is weak. Particularly many of the same pharmaceuticals were found in three different locations. These multiple locations present an opportunity for pilferage and poor stock management/control.
9. The main supply room is cluttered. The space is adequate, but items for hospital use and other items stored for outside projects are mixed together, including patient care equipment. A lack of organization makes it difficult for inventory control and accountability.
10. The medical records department is severely handicapped by the lack of department space.

RECOMMENDATIONS:

1. Replace current method of purchasing / stores / distribution with a *system of supplies management.* A system that establishes a clear flow of process activities to control costs of procurement and inventory beginning with user requests and ending with timely distribution of requested items to user departments. This system will also help to improve availability of supplies. Technical support is required.
2. Once the new system of supplies is functional, either from the outset or after a pilot implementation, replace the ward stocks of bulk pharmaceuticals with individual patient-prescribed items- in the interest of reducing costs, and improving control, accountability, and patient safety.
3. Organize a multidisciplinary *Personnel Committee* to review staffing levels, based on need, by department.
4. Organize a multidisciplinary *Space Committee* to review utilization of existing space for appropriateness
5. Organize a committee of nurses, clinical officers, medical officers, and consultants to develop: 1) *admission criteria; 2) clinical treatment protocols; 3) develop a utilization review plan-* to review extended inpatient stays, and appropriate utilization of hospital resources. These activities are designed to control admissions to eliminate overcrowding, and control/reduce operating costs. Technical support is required.
6. A *management development/training program* should be developed to include management theory, leadership and team building, communication skills, planning and goal setting, and financial skills and budgeting. *Customer Care training* for all staff is also suggested. Technical support is required

III. PATIENT CARE ISSUES:

FINDINGS-

1. Some of the wards are frequently overcrowded which increases the risk of hospital acquired infections and patient/family dissatisfaction with services/care, an lowers staff morale and productivity.
2. The ward staff, in general, complain about the lack of supplies and basic patient care equipment
3. In the interest of quality and safety of patient care, there is no consultant anesthesiologist. The previous one was transferred to KNH.
4. The casualty service is in need of additional space.

RECOMMENDATIONS-

1. Utilization of the wards needs to be studied. Some consolidation of beds/wards may be possible and will help to offset overcrowding, lower the risk of infections, and overwork of nursing staff.
2. A pilot demonstration should be developed and implemented for distribution of supplies to user departments, especially patient wards, utilizing stores clerks. Using nurses as delivery staff contributes to the perceived shortage of nursing staff, removes the nurse from the patient care environment and negatively impacts the nurse's job satisfaction and productivity.
3. The practice of maintaining "ward stock" should be evaluated in terms of improving inventory control and reducing the opportunities for hoarding and pilferage. The desired outcome could conceivably help to reduce frequent supply shortages, and lower costs.
4. Organize a committee of nurses, clinical officers, medical officers, and consultants to develop: 1) *admission criteria; 2) clinical treatment protocols; 3) utilization review plan* - to review extended inpatient stays, and appropriate utilization of hospital resources. These activities are designed to control unnecessary admissions to eliminate overcrowding, and control/reduce operating costs. Some technical support is required.

IV. FINANCE AND ACCOUNTING ISSUES:

FINDINGS-

1. A Financial Management Information System (FMIS) is not in place. The management does not receive accurate and timely information to assist in planning and decision-making. Patient activity and financial data are not integrated. A cash accounting system is in place. All accounting is done manually.
2. An accounts assistant who is on secondment from the District Treasury heads the accounts department. He has CPA I, Section I qualification. All the other accounting department staff are not trained accountants but mainly bookkeeping clerks with basic secondary education. None are computer literate.
3. Revenue and Expenditure budgets are not prepared. Expenditures are prioritized based on monies collected.
4. There are three cash collection points situated at the NHIF office (for inpatients), the pharmacy and the lab. The pharmacy and lab cash points are close to one another. The hospital management suspects that they are losing revenue through the use of MR receipts that can easily be manipulated.

5. The involvement of the District Treasury in the approval of payment vouchers leads to unnecessary delays in procurement of goods and services. Where emergencies have occurred in the past, this delay has resulted in an inevitable spending of FIF funds at source (before banking).
6. There is no formal analysis of volume of services rendered and revenue earned from those services. This means that the hospital does not estimate the expected collections based on workload statistics.
7. The hospital management does not remit 25% of collections to DMOH for PHC activities as per the FIF policy guidelines. The hospital management does not intend to surrender the 25% of FIF as in their opinion no PHC services are rendered.
8. The hospital total revenue position is not known because not all income due to the hospital is captured or accounted for.

RECOMMENDATIONS-

1. Design and implement a Financial Management Information System (FMIS). Critical to effective management performance is the need for accurate and timely information. The FMIS should be modular, so it can be phased in, and will integrate patient activity and financial data. Some technical support is required.
2. With the MoH moving towards decentralization of public hospitals, qualified accounting staff to manage the hospital finances will be a necessity. Since it is not possible to attract qualified accountants in public hospitals, the hospital management should consider investing in the training of selected existing clerks in accounting and basic computer applications.
3. The hospital management should involve all departments/units in preparation of annual revenue and expenditure budgets. The department heads should be made responsible for their departmental budgets. The budgets should be reviewed on a quarterly basis by comparing the actual collections and expenditures against what was budgeted. Variances should be explained.
4. The three cash collection points are adequate. However, the lab and pharmacy cash points are adjacent. It might be advisable to relocate one cash point to OPD and operate only two locations to reduce the opportunity for abuse. To enhance revenue collection the hospital might want to invest in two stand-alone cash registers to begin with. The registers will help to seal loopholes arising from the misuse of MR receipts. Some technical support is required.
5. The accounting functions for the FIF funds should be done at the hospital since the District Treasury has accountants already working at the hospital. This will minimize the frustrations of the hospital staff and also expedite approval of valid expenditure. All accounting books and records should be maintained by the hospital.
6. Departments should be encouraged to estimate the expected revenue based on services provided. The expected revenue should then be compared with the reported revenue. Any variances should be explained. This check will ensure that cashiers/ revenue clerks do not tamper with the duplicate MR receipts.
7. It is recommended that the remittance of 25% of FIF funds to DMOH for PHC activities be done as per FIF policy guidelines. Issues of accountability of those funds by the DMOH should be raised with the relevant authorities.
8. All services provided to the patients should be billed and recorded whether the patient is paying or not. This will allow the management to know the total revenue potential and how much revenue is lost through waivers, exemptions, absconders and other bad debts.

V. HOSPITAL MANAGEMENT FEEDBACK:

At the conclusion of the assessment survey, a summation conference was held with senior hospital management to present the preliminary findings and conclusions. This was the same group of individuals present at the opening meeting with the medical superintendent, plus 2 additional nursing matrons. This summation conference is also an opportunity for senior management feedback, to provide additional supportive information and ask questions for clarification.

Additional Feedback

- GoK procedures are cumbersome, tedious, and cause delays which interfere with the hospital's provision of medical care for the citizens of Kenya.
- The District Treasurer is a barrier to patient care in that the approval of vouchers to procure required goods and services takes too long. Sometimes bribes have to be given before approval is granted.
- There is manipulation of manual receipts. Will set up a procedure to monitor collection in wards. Interested in installation of cash registers like Coast PGH.
- Board appointments did not include one member recommended by the hospital
- Not willing to surrender 25% to DMOH
- Board should have authority commensurate with responsibilities. They feel they have a lot of responsibility without authority.

RIFT VALLEY PROVINCIAL GENERAL HOSPITAL – NAKURU

JUNE 8-9, 1999

I. HOSPITAL PROFILE:

RIFT VALLEY PROVINCIAL GENERAL HOSPITAL **Key Statistics**	
Catchment Area Population	Unknown
Total No. Beds	656
Total No. of Staff	1,022
Doctors/Consultants	19
Medical Officers	13
Clinical Officers	43
Nurses	526
Clinical staff	36
Other / Admin. / Subordinate	364
Expenditure – Cost Sharing – 1998	17,427,199
Expenditure - Recurrent	16,292,930
Drugs & Supplies (%) -C. Sharing – 1998	51%
Drugs & Supplies (%) –recurrent	5%
Recurrent AIEs –1998/99	16,522,720

Income – Cost Sharing –1998	11,763,726
NHIF Income	2,919,000
NHIF Outstanding Claims	862,000
Cash Collection Points	7
Admissions	22,845
ALOS	6
Occupancy %	70%
Total Outpatient Visits – 1998	122,005
Total Surgical Operations - `1998	2,385
Total OB Deliveries – 1998	4,567
Daily Inpatient Charge (General ward)	100
Satellite Units	Amenity Annex

RIFT VALLEY PROVINCIAL GENERAL HOSPITAL

NAKURU

OPERATIONAL ASSESSMENT ACTIVITY SCHEDULE

DATE/TIME	DEPARTMENT	INDIVIDUAL	PURPOSE
June 8, 9am	Executive Mgt.	Dr. Sonoiya, Med. Supt., and Senior Management Team	Organogram, scope of services, bed complement, and review agenda
11am	Personnel	Mr. Wachira, Pers. Officer	Staffing complement, shortages/overages, problems
11:30am	Accounting Purchasing/stores	Ms. Gathuo Mrs. Mungatia	Financial- budget, revenue/expense Procedures- purchasing, stores

			and distribution- Problems
12 noon	Hosp. Board Chm.	Mr. Tuiyot	Board Activity, Concerns
12:30 pm	Med. Staff leaders	Drs. Sonoiya, Ndede, Obure, Ochoki	Bylaws, Manpower concerns, barriers to quality
2pm	Pharmacy	Dr. Ndegwa	Functions, Concerns
2:30pm	Laboratory	Dr. Siminyu	Functions, Concerns
3pm	Med. Records	Mr. Kelunyo	Functions, patient activity statistics
June 9, 9am	Nursing Admin	Mrs. Waweru, Mrs. Omoll	Organogram, barriers to quality care, CE, wards tour
12:30	Radiology,	Mr. Sompisha	Functions, Concerns
2 pm	Exit Conference	Drs. Sonoiya and Ombito, Mr. Barclay, board officer, senior and mid level managers,	Presentation of preliminary findings and recommendations

I. ORGANIZATIONAL ISSUES:

GENERAL OBSERVATIONS-

- Hospital provides a broad scope of patient services much the same as other PGHs plus a new facility soon to be operational for counseling and treatment of HIV patients
- There are numerous separate facilities / structures dispersed over 50 acres
- External improvements in process to buildings and grounds are evident
- Hospital operates an amenity hospital annex of 48 beds approximately 1km off site offering medical, surgical and maternity services.
- Operating organizational structure is appropriate.
- The hospital board appears very active in hospital operations. The Chairman has an office on-site.
- Hospital management has prepared a comprehensive 5-year Business Plan (Financial data has not been included)

FINDINGS:

1. There is no computerization. All information is collected and reported manually.
2. There is a 5-year business plan beginning 1 July 1999.
3. Hospital is doing some external marketing by encouraging medical practitioners outside the organization to use Rift Valley PGH amenity wards for their paying patients.
4. The hospital board appears to be involved in day-to-day operations, and this may be due to management encouraging them to problem solve, which gives an indication that management is abrogating one its core responsibility of hospital administration.

RECOMMENDATIONS-

1. Board members would benefit from a training workshop for new board members, to clarify their roles and responsibilities, and those of management. Technical support is required.
2. A *management development/training program should be developed* to include management theory, leadership and team building, problem solving, communication skills, planning and goal setting, and financial skills and budgeting. *Customer Care training* for all staff is also suggested. Technical support is required.
3. Organize a multidisciplinary *Personnel Committee,* chaired by Director of Personnel, to review staffing levels, based on need, by department.
4. Organize a multidisciplinary *Space Committee* to review utilization of existing space for appropriateness
5. In the hospital's marketing effort to encourage other practitioners to admit their private paying patients to the amenity ward, ensure the "amenities" are functioning well to assure patient and doctor satisfaction. An unhappy patient, and the doctor, will not return and they will tell others of their unsatisfactory experience.

II. PATIENT CARE ISSUES:

FINDINGS-

1. Some of the wards are frequently overcrowded which increases the risk of hospital-acquired infections and patient/family dissatisfaction with the quality of services/care. (especially the pediatric ward)
2. The existing supplies system does not work well for patient wards. For example, nurses walk a significant distance across the campus to obtain pharmaceuticals for inpatients from the outpatient pharmacy, while a pharmaceutical store is near the inpatient wards and could be staffed at specific times allowing distribution to the inpatient wards.
3. Like other PGHs, the most frequent complaint from staff is the lack of supplies, drugs, and basic patient care equipment in order for staff to be productive.
4. Like other PGHs, the perception is that there is a shortage of nursing staff.
5. Physician manpower needs: consultant anesthesiologist and radiologist

RECOMMENDATIONS-

1. Utilization of the wards needs to be studied. Some consolidation of beds/wards may be possible and will help to offset overcrowding, lower the risk of infections, and overwork of nursing staff.
2. A pilot demonstration should be developed and implemented for distribution of supplies to user departments, especially patient wards, utilizing stores clerks. Using nurses as delivery staff contributes to the perceived shortage of nursing staff, removes the nurse from the patient care

environment and negatively impacts quality of patient care, the nurse's job satisfaction and productivity.

3. Replace current method of purchasing / stores / distribution with a *system of supplies management.* A system that establishes a clear flow of process activities to control costs of procurement and inventory beginning with user requests and ending with timely distribution of requested items to user departments. This system will also help to improve availability of supplies. Some technical support is required.
4. The practice of maintaining "ward stock" should be evaluated in terms of improving inventory control and reducing the opportunities for hoarding and pilferage. The desired outcome could conceivably help to reduce frequent supply shortages and improve employee job satisfaction.
5. Organize a committee of nurses, clinical officers, medical officers, and consultants to develop: 1) *admission criteria; 2) clinical treatment protocols; 3) utilization review plan*- to review extended inpatient stays, and appropriate utilization of hospital resources. These activities are designed to control unnecessary admissions to eliminate overcrowding, and control/reduce operating costs. Technical support is required.
6. In the interest of patient care, there is an urgent need for a diagnostic radiologist.

III. FINANCE AND ACCOUNTING:

FINDINGS-

1. A Financial Management Information System (FMIS) is not in place. The management does not receive accurate and timely information to assist in management. Patient activity and financial data are not integrated. The cash accounting system is in place. All accounting is done manually.
2. An Accountant on secondment from the District Treasury heads the accounts department. She has CPA II, qualification. Her assistant, also from the District Treasury, has CPA II qualification as well. One other cashier is pursuing the CPA. Other accounting department staff are not trained accountants but are mainly book keeping clerks with basic secondary education. Apart from the accountant and her assistant, all other accounting department staff are not computer literate.
3. Revenue and Expenditure budgets are not prepared. Expenditures are prioritized based on the amount of money collected. All collections are banked intact (no spending at source). An emergency fund has been set up to deal with emergencies.
4. The three members of staff who were trained in costing of hospital services in April this year have begun the application of costing.
5. There are seven cash collection points. The hospital service centres are spread over a wide area.
6. The involvement of the District Treasury in the approval of payment vouchers leads to unnecessary delays in procurement of goods and services. Where emergencies have occurred in

the past, this delay has resulted in an inevitable spending of FIF funds at source (before banking). This situation has now been corrected with the setting up of an emergency fund.

7. There is no formal analysis of volume of services rendered and revenue earned from those services. This means that the hospital does not estimate the expected collections based on workload statistics.
8. The pharmacy department keeps parallel records of patient receipts when issuing drugs. This is compared with the cashier duplicate receipts.
9. The hospital management remits 25% of collections to DMOH for PHC activities as per the FIF policy guidelines.
10. The hospital intends to introduce ward clerks to assist in inpatient billing and also assist in controlling the rampant absconding of inpatients.
11. The hospital total revenue position is not known because not all income due to the hospital is captured.

RECOMMENDATIONS-

1. Design and implement a Financial Management Information System (FMIS). Critical to effective management performance is the need for accurate and timely information. The FMIS should be modular, so it can be phased in, and will integrate patient activity and financial data. Some technical support is required.
2. With the MoH moving towards decentralization of public hospitals, qualified accounting staff to manage the hospital finances will be a necessity. Since it is not easy to attract fully qualified accountants in public hospitals, the hospital management should consider investing in the training of selected existing clerks in accounting and basic computer applications.
3. The hospital management should involve all departments/units in preparation of annual revenue and expenditure budgets. The department heads should be made responsible for their departmental budgets. The budgets should be reviewed on a quarterly basis by comparing the actual collections and expenditures against what was budgeted. Variances should be explained.
4. Understanding how much it costs to provide health services is useful to managers in planning and also fee setting. The hospital staff should be encouraged to complete the costing exercise that is currently going on.
5. The hospital management should consider reducing the number of cash collection points to minimize the risk of misappropriation of funds. The decision on the cash points to retain should be made based on distance, patient access, and the volume of services at each location.

6. The accounting functions for the FIF funds should be done at the hospital since the District Treasury has accountants already working at the hospital. This will minimize the frustrations of the hospital staff and also expedite approval of valid expenditure. All accounting books and records should be maintained by the hospital.
7. Departments should be encouraged to estimate the expected revenue based on services provided. This should then be compared with the reported revenue. The pharmacy department's parallel record keeping should be emulated by other departments. This check will ensure that cashiers/ revenue clerks do not tamper with receipts.
8. The surrendering of 25% of FIF to DMOH for PHC activities should continue. Issues of accountability of those funds by the DMOH should be raised with the relevant authorities.
9. The deployment of clerks to each ward for inpatient billing should be assessed to determine their contribution to capturing patient charges and by assisting with non nursing duties. A cost benefit analysis should be done to establish if this change is cost effective.
10. All services provided to the patients should be billed whether the patient is paying or not. This will allow the management to know the total revenue potential and how much revenue is lost through waivers, exemptions, absconders and other bad debts.

V. HOSPITAL MANAGEMENT FEEDBACK:

At the conclusion of the assessment survey, a summation conference was held on hospital grounds under a large tree. Attendees included: the medical superintendent, Dr. Sonoiya, both senior and middle management staff, representatives of the medical staff leadership, and an officer of the hospital board.

Additional Feedback:

- Requests technical assistance to complete hospital costing
- Need management training and development

SUMMARY FEEDBACK - ALL PGHS

- GoK procedures are cumbersome, tedious, and cause delays which interfere with the hospital's provision of medical care for the citizens of Kenya.
  - The District Treasurer is a barrier to patient care in that approval of vouchers to procure required goods and services takes too long. Sometimes bribes have to be given before approval is granted.
  - Hospitals acting independently would have much more opportunity to negotiate lower prices with suppliers because they will not negotiate with PGHs due to the slow pay reputation of the GOK.
  - The major supplier of drugs and supplies to the hospital is the MSCU by issuing pre packed general patient care "kits". These kits are not particularly cost effective because the contents are not based on patient need, that is, by the prevailing medical diagnosis experience in the PGH's service area. Consequently, one hospital may require more anti malarial drugs and another may require substantially less. This system of kits is therefore fraught with wastage and expired items, and should be reviewed for cost benefit/effectiveness.
- MoH personnel section—problems of ghost payroll exists that have not be corrected by MoH HQ. Staff receive unauthorized allowances (hardship). Ineffective discipline procedures even in the serious case of theft of government resources do not get resolved and in most instances the hospital ends up taking the problem employee back, and in some cases with a promotion. These few examples only further handicap the hospital's attempt to effectively manage its human resources in the attempt to become self sustaining.
- The major hospital staff concerns are same at all PGHs- lack of supplies and basic equipment, lack of training, low job satisfaction and low morale, shortage of nursing staff. Much of the diagnostic equipment is non functioning due to a lack of spare parts or obsolescense, and lack of funds for maintenance of buildings and equipment.
- PGH's are willing to provide primary care activities directly from the PGH rather than remitting the 25% of FIF to DMOH.
- A general orientation and training of hospital boards is needed to clarify member's roles and responsibilities and those of management.
- Hospital management training and development is a high priority.

PROVINCIAL GENERAL HOSPITAL ASSESSMENTS PROFILE COMPARATIVE KEY STATISTICS			
	Nyanza PGH Kisumu	**Nyeri PGH Nyeri**	**Rift Valley PGH Nakuru**
Catchment Area Population	Unknown	Unknown	Unknown
Total No. Beds	338	400	656
Total No. Staff	554	633	1,022
Consultant Doctors	18	31	40
Medical Officers	5	NA	13
Clinical Officers	16	NA	43
Nurses	313	328	526
Clinical staff	15	27	36
Other / Admin./ Subordinates	199	247	364
Expenditure – Cost Sharing	32,292,599	11,730,986	17,427,199
Expenditure - Recurrent	14,453,116	10,502,727	16,292,930
Drugs & Supplies (%) –C. S.	29%	NA	51%
Drugs & Supplies (%) – Recurrent	4%	NA	5%
Recurrent AIEs -1998/99	16,749,300	10,564,960	16,522,720
Income – Cost Sharing –1998	14,192,102	14,213,759	11,763,726
NHIF Income	5,044,400	1,894,000	2,919,000
NHIF Outstanding Claims	7,826,955	1,181,000	862,000
Cash Collection Points	2	3	7
Total Admissions – 1998	10,920	12,455	24,284
ALOS	10	NA	6
Occupancy %	81%	82%	70%
Total Outpatient Visits – 1998	148,385	NA	122,005
Total Surgical Operations- 1998	850	NA	2,385
Total OB Deliveries – 1998	3,980	5,911	4,567
Daily Inpatient Charge(General)	100	100	100
Satellite Units	Amenity Annex	None	Amenity Annex

Some of the above requested financial and patient activity operational data was not readily available, in some cases incomplete, and not organized when presented. This gave the impression that there is no system for collection and integration, and that the data is not regularly reviewed and used by management to support the planning and decision-making activities, nor is it shared routinely with the governing board.

SCORING ASSESSMENT FINDINGS

A scoring method and ranking measurement was developed to identify and rank in order those facilities which represent the highest potential to benefit from AFS' technical support and assistance, based on the experience gained from the Coast PGH

PERFORMANCE INDICATORS	MAX SCORE	INTERPRETATION
1. Hospital with primary care clinics serving a population of >= 150,000.	10	High score from large hospital with primary services
2. Strong involvement of the board but lacking clarity in roles/responsibilities	10	Stronger involvement gives higher score
3. Strong involvement of hospital management team but weak management skills	10	Stronger involvement gives higher score
4. Significant cost recovery capability but possible	10	Higher proportion of revenues from user fees and

slowing in revenue growth		insurance and lower levels of bad debts and dependence on external donations give higher score
5. Willingness to engage in cost containment measures	10	More willing, more points
6. Level of competition from Private/NGO sector	10	High score means no overbedding in area (< 1 bed/1000)
7. High rates of maternal and child mortality and morbidity	5	Higher rates give higher score
8. Long term strategic plan	10	Plan gives high score
9. Logistical ease of mobilising technical assistance in remaining 15 months of project.	10	Shorter travel time to site gives higher score
10. No departmental planning & budgeting	10	Absolute lack and robust systems give lower score
11. Higher proportions of revenues derived from NHIF/other insurance schemes	10	More insurance revenues give higher score
12. Potential for replication through secretariat support	10	Central coordinating body gives higher score
13. Strong financial and accounting procedures	10	Too strong, too weak gives low score
14. Maturity of basic management systems	10	Too weak, or too mature gives low score
Maximum Score Possible	**135**	

SCORING RESULTS OF ASSESSMENT

A scoring method and ranking measurement was developed to identify and rank in order those facilities which represent the highest potential to benefit from AFS' technical support and assistance, based on the experience gained from the Coast PGH

CRITERION	MAX	INTERPRETATION	Nyeri	Nakuru	Kisumu
1. Hospital with primary care clinics serving a population of >= 100,000.	10	1 point per 50,000 with clinics .5 point per 50,000 w/out clinics Zero score for unrealistic estimates over 1 million or under 50,000	0	0	0
2. Strong involvement of the board but lacking clarity in roles and responsibilities	10	2 Points Meets regularly 2 Points Presence of quorum 2 Points Participation in planning 4 Points Participation in Monitoring & Evaluation	6	8	6
3. Strong involvement of hospital management team but weak management skills	10	2 Points Meets regularly 2 Points Discusses problems & their resolution 2 Points Regular review of business systems for improvement 2 Points Monitoring of Revenues & Expenditures 2 Points Conducts management rounds of hospital	6	6	8
4. Significant capability and/or potential for cost recovery & sustainability but possible slowing in revenue growth	10	2 Points High volume of patient activity 2 Points Appropriate fee structure 2 Points Active committees that review and standardize drugs & supplies 2 Points At least 75% of revenues from user fees and insurance 2 Points Less than 10% of expenditure allocated toward servicing bad debt -2 Points Donations over 25% of Revenues	8	8	8
5. Opportunity and or willingness to engage in cost containment measures	10	2 Points Existence of Departmental Expenditure Targets 2 Points Monthly Review of Departmental Targets 2 Points Existence of Committee for Review of staffing levels 2 Points Monthly Review of Departmental staffing levels 2 Points Existence Committee for Review of drugs & supplies needs 2 Points Monthly Review of drugs & supplies needs	N/A	N/A	N/A
6. Level of competition from Private/NGO sector	10	High score means no over bedding in area (< 1 bed/1000)	Unable to determine	Unable to determine	Unable to determine
CRITERION	**MAX**	**INTERPRETATION**	**Nyeri**	**Nakuru**	**Kisumu**
7 .High Rates of Maternity and Child Morbidity, Mortality	5	1 Point per Population based Child Mortaility Rate increase of 2-/1000 live births. Scores 1, 40/1000 scores 2 etc.	2.5	4	

					9
8. Existence of Institutional Plan	10	4 Points Existence of short term or medium term Plan with numeric targets 2 Points Plan prepared with wide input from staff 2 Points Plan prepared with wide input from management 2 Points Plan prepared with wide input from board	4	6	4
9. No Departmental Planning/Budgeting	10	Lack of and robust systems give lower results	4	8	4
10. Logistical ease of mobilizing technical assistance in remaining 15 months of project.	10	-4 Points Over 6 hours travelling time 4 points Under 2 hours travelling time 2 points Reliable local taxi service 2 Points Suitable hotels 4 Points Air travel possible	8	8	10
11. Higher proportions of revenues derived from NHIF/other insurance schemes	10	More insurance revenues give higher score	4	6	8
12. Potential for replication through secretariat support	10	Central coordinating body gives higher score Applicable to non government hospitals only	N/A	N/A	N/A
13. Maturity of basic management systems	10	2 Points Departmental planning & budgeting 2 Points Annual Budgeted Revenues & Expenses by department 2 Points Monthly Budgeted Revenues & Expenses by department 2 Points Manual Cash Accounts only 2 Points Manual Patient Registration only 3 Points Manual Accrual Accounts only 4 Points Single User Computerized Cash Accounts 5 Points Single User Computerized Accrual Accounts 6 Points Networked Accrual Accounts 8 Points Networked Accrual Accounts w/ patient records -8. Full HMIS (Does not need help!) (Too weak, or too mature gives low score)	4	4	4
14. Presence of Patient Activity Data	10	2 Points Registers only 2 Points Daily summary of OBD. O/P by dept, lab, xray etc 2 Points Monthly summary of activity statistics 4 Points Multi year trend analysis	4	6	6
Maximum Score Possible	135		50.5	64	67

NEXT STEPS

The AFS Project has developed, as a result of the experience with Coast Provincial General Hospital, a hospital systems reengineering package for improving organizational performance and reducing costs. This reform package consists of the following elements which can be adapted to the particular status of any hospital:

PURPOSE:

To improve organization performance and quality of services, enhance revenues, control costs, and improve patient/staff satisfaction.

MODELS/SYSTEMS	IMPROVEMENT GOALS		
	Org Perf-Qual	**Rev/Costs**	**Patient/Staff Satisfaction**
1. Training - **Hospital Board-** Roles & Responsibilities	X		
Hospital Management - Supervisory Skills, Planning, Teamwork, Communication, Roles	X	X	
Hospital Staff- Customer Care	X	X	X
			X
2. Patient Care Delivery System- **Medical Staff Organization-** Bylaws, Rules and Regulations, Peer Review, Medical Care Review	X	X	
Utilization Management - criteria for admission, review of extended stay and use of clinical support services for appropriateness,	X	X	
			X
Clinical Protocols - to improve clinical practice patterns thereby reducing the overall cost of care and enhancing the quality	X	X	
			X
3. Administration and Financial Information System- To Aggregate Administrative, Financial Accounting, and Clinical Data to support decision making, patient care, management and operations performance improvement	X	X	
			X

A SUMMARY COMMENT:

Based on the discussions with the management teams at the PGHs, the Project recommends further decentralization of the central management authority. It is also recommended that the MOH clearly articulate what authority is to be delegated followed by a rapid planned implementation in those hospitals that already have a demonstrated capacity to manage, but with the necessary support to assist them to make the necessary changes.